STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

APPLICATION FOR LICENSURE/CERTIFICATION
ALCOHOL & DRUG TREATMENT PROGRAM

DATE: _____

APPLICATION IS FOR: NEW LICENSE/CERT._____ RENEWAL OF LICENSE/CERT._____

ADD A SERVICE: _____ ADD A SITE: _____ ADD AFFILIATE: _____

NAME OF FACILITY/AGENCY: _____

ADDRESS:
_____
_____
_____
(City, State, Zip)

MAILING ADDRESS: (if different)
_____
_____
_____
(City, State, Zip)

COUNTY _____

NAME OF CONTACT PERSON: _____

PHONE # _____ FAX # _____ EMAIL _____

NAME/TITLE OF ADMINISTRATOR/OPERATOR: _____

PHONE # _____ FAX # _____ EMAIL _____

NAME OF EXECUTIVE DIRECTOR: _____

SOCIAL SECURITY # OR EMPLOYER ID #: _____

CORPORATION NAME/ADDRESS (if different): _____
_____
_____

TYPE OF FACILITY/AGENCY:

Individual Proprietorship: _____ Partnership: _____
Non-Profit Corporation: _____ For-Profit Corporation: _____
Tribal Government: _____ Parent Co-op: _____
Church: _____ Other (describe): _____

CURRENT LICENSES/CERTIFICATES:

Type: _____ Terms: _____ Exp. Date: _____

Type: _____ Terms: _____ Exp. Date: _____

WAIVER / EXCEPTION REQUEST OR RE-REQUEST (If applicable) DESCRIBE:

_____
_____
_____
_____

I/We have received and read the rules for the licensing and/or certification process. I/We understand that this application authorizes representatives of the Department of Health and Human Services and the State Fire Marshal's Office (if applicable) to make such visits and inspections as may be necessary to ensure that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department of Health and Human Services to obtain any criminal or protective records information which may be on file in any Country, State or Federal Office.

I/We further certify that all information contained in this application (including Addendum) is complete and accurate.

ORIGINAL SIGNATURES REQUIRED:

_____/ DATE: _____
Applicant/Operator/Administrator

_____
Type or Print Name

_____/ DATE: _____
2ND Applicant (If Applicable)

_____
Type or Print Name

_____/ DATE: _____
Board President (If Applicable)

_____
Type or Print Name

FURTHER INSTRUCTIONS:

1. COMPLETE THE ATTACHED ADDENDUM SPECIFIC TO THE TYPE OF LICENSURE OR CERTIFICATION THAT IS BEING APPLIED FOR.

2. SUBMIT ALL ITEMS REQUESTED IN THE "**PLEASE SUBMIT" SECTION** OF THE FORM.

ADDENDUM
APPLICATION FOR – ALCOHOL & DRUG TREATMENT PROGRAMS
(Not Children's Residential Program)

APPLICATION FOR: _____ License (Residential Treatment Program)
_____ Certificate of Approval (Non-Residential Treatment Program)

FACILITY ADDRESS/PHONE (If different from previous):
_____ / PHONE: _____

CATCHMENT AREA: (Geographic Area Served): _____

CONTACT PERSON (If different from previous): _____
**Attach additional sheets for multiple sites if necessary.*

CHECK EACH COMPONENT TO BE REVIEWED:

RESIDENTIAL LICENSE: (Service)
_____ Detox, Medical Model-----Number of Beds _____
_____ Detox, Social Setting ------Number of Beds _____
_____ Shelter----Number of Beds _____
_____ Extended Shelter---- Number of Beds _____
_____ Assisted – Medical Model----- Number of Beds _____
_____ Extended Care Residential Rehab--- Number of Beds _____
_____ Halfway House--- Number of Beds _____

CERTIFICATE: (Service)
___ Outpatient Care ___ Non-Residential Rehab ___ DEEP-Driver Ed. Evaluation Program ___ Methadone Treatment

ALL APPLICANTS PLEASE SUBMIT:

1. Completed Application **AND**
2. Application Fee – **$50.00** Non-Refundable application Processing Fee **AND/PLUS**
   a. **$50.00** For Each Service Checked Off Above (new and renewal applications);
   b. **$25.00** Fee to Add A Service to an Existing Site ($25.00 per each new service)
   c. **$25.00** Fee to Add Each New Site ($25.00 per each new site)
   Make check payable to: TREASURER, STATE OF MAINE
3. Fire Inspection Form (Required for ALL New Sites)
4. Organizational Chart
5. List of Governing Body Members/Offices Held/Addresses
6. Staff Roster
7. Program Descriptions
8. Program Admission Criteria for each program
9. Any new or changed policies
10. Submit current water test for each site not on public water

FIRST TIME APPLICANTS ALSO MUST SUBMIT:

1. Articles of Incorporation
2. Assurance of Compliance (ADA/EEO)
3. Complete Policy and Procedure Manual
4. Sample Client File

FOR EACH SERVICE YOU PROVIDE LIST THE MAXIMUM TOTAL NUMBER OF CLIENTS YOUR AGENCY WILL SERVE AT ALL LOCATIONS, THE AGE RANGE, AND GENDER. (Use additional sheets if necessary.)

SERVICE:_____ # OF CLIENTS_____AGE RANGE:_____GENDER _____

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SERVICE:_____ # OF CLIENTS_____AGE RANGE:_____GENDER _____

SUBMIT APPLICATION TO:

ATTN: Brian McAuliffe
Department of Health and Human Services
11 State House Station, 442 Civic Center Drive
Augusta, ME 04333-0011

Phone: (207) 287-9250 Fax: (207) 287-9252 TTY: 800-606-0215

STAFF ROSTER

FULL NAME ________________________________ TITLE ___________DATE OF BIRTH ____________
EDUCATION/DEGREE ___________________ LICENSE/CERTIFICATION______________________
SUPERVISOR____ TITLE ___________________________

FULL NAME ________________________________ TITLE ___________DATE OF BIRTH ____________
EDUCATION/DEGREE ___________________ LICENSE/CERTIFICATION______________________
SUPERVISOR____ TITLE ___________________________

FULL NAME ________________________________ TITLE ___________DATE OF BIRTH ____________
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EDUCATION/DEGREE ___________________ LICENSE/CERTIFICATION______________________
SUPERVISOR____ TITLE ___________________________

(Use additional sheets if necessary.)

FIRE INSPECTION REQUEST & ADDRESS CHANGE FORM
Type of License/Certification: ALCOHOL AND SUBSTANCE ABUSE

Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.

FORM MUST BE COMPLETED BY:

1. New Applicants: Complete one form for each site from which you plan to deliver services and return with your application. (NEED ONE FORM FOR EACH SITE)

2. All Applicants: Complete and submit form when you are adding a site, changing your address, or closing a site. (KEEP A COPY OF THE FORM FOR YOUR RECORDS)

MAIN SITE:
Agency Name: _____ Date: _____
Operator/Exec. Director: _____ Phone: _____
Address: Contact Person (if different):
_____ _____
_____
_____ Phone: _____
(City, State, Zip)

DESCRIPTION OF SERVICES: _____
_____

AGE RANGE OF CLIENTS SERVED: _____ MAXIMUM CAPACITY: _____

RESIDENTIAL: _____ NON-RESIDENTIAL: _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks.) _____
_____
_____
_____

COMPLETE ONLY IF CHANGE:
Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.

New Program/Agency In Process of Licensure _____

Closing Existing Site _____ *Address:* _____
_____

Moving Office Site Within Same Building _____

Adding New Site _____ *Address:* _____
_____

NEW SITE: Date of Expected Move: _____
Contact Person: _____ *Phone:* _____

WATER SOURCE: Municipal _____ *Well* _____ *Other* _____

*DIRECTIONS TO FACILITY: (Be specific with known landmarks.)*_____
_____
_____
_____